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ABSTRACT

There is a lack of systematic methods for effective implementation of meaningful consumer and community participation, which is a major factor contributing to critical deficiencies and imbalances in the planning and implementation of human services programs. A constituency-based approach for the development of service acquisition systems is described and a case of its successful application is presented. Part I of the paper reviews the case for consumer/community participation and the problems associated with the concept in relation to health service delivery. The concept of a balanced service system which goes beyond past attempts at developing consumer/community involvement is then presented. Part II describes the constituency-based approach and offers a brief case study of an actual application to the development of a management training acquisision network. It defines characteristics of a service acquisitions system and develops a conceptual model. (Author/BEF)

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Balancing Acquisition With Delivery in Human Services Program Development

by

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Balancing Acquisition With Delivery in Human Services Program Development

Part I

The principle of involving consumers in the planning and implementation of various human services has been invoked long before the Great Society programs of the 1960's. However, it was during this period that a renaissance of the concept occurred, fueled by the civil disturbances of the era and the resultant urgency to find ways to alleviate the social ills being spotlighted. Attempts to involve consumers and communities ranged from the use of consumer representatives in advisory capacities, to the actual granting of monies by the Office of Economic Opportunity to community-controlled organizations. Overall opinion on the effectiveness of these strategies is mixed, but little evidence exists to indicate that significant participation by persons truly representative of consumer and community interests has occurred to any great extent.[1] Nor does it appear that by simply allowing such representation in various policy-making, planning and evaluation activities do services necessarily improve.[2]

Even with this lack of clear, empirically-demonstrated evidence that consumer/community participation does improve services the idea is still adhered to as an underlying principle especially by federal funding agencies. Regulations that guide the implementation of most HEW programs require consumer/community participation to some degree. The National Health Planning

and Resources Development Act and the Community Mental Health Centers Act (as amended in 1975) are two notable examples which require a consumer involvement in health and mental health planning by governing bodies.

Consumers and communities participate in many ways. Advisory groups, volunteer programs, and advocacy groups are vehicles for participation. Consumer and community opinion on service needs is sought through needs assessment surveys, hearings and forums during the planning stages for new services, and through various satisfaction surveys as part of evaluation studies.

In the field of mental health most of these avenues of participation exist for consumers and communities. The N.I.M.H. guidelines require that Community Mental Health Centers (CMHC's) be planned on the basis of community needs assessment, that their governing Boards reflect the minority and economic composition of the community, that they be composed of no more than half health-care providers, and that evaluation programs include consumer/community satisfaction surveys. But beyond such CMHC-related activities few mandated participative mechanisms exist. State hospitals, unless they receive special federal project monies, are not under any systematic federal requirements to provide for participation. There is little opportunity for communities and consumers to impact on the private mental health practitioner and hospital. The degree of participation within private organizations such as Family Service Agencies, church-affiliated services, United Way agencies and the like varies widely according to the organization's tradition and the inclination of its Board and administrators.

Problems with Consumer/Community Participation.

The issues surrounding community/consumer participation in mental health services are difficult, as they are in all human service systems. First is the problem of determining the best mechanisms through which consumers and

communities can participate. Second is the need for coordinating such participation (just as there is the need to coordinate service delivery) among a wide range of very different service organizations at the local, state, and national levels. However, the pressure to squarely address the problem is increasing, particularly with the publication of the Report to the President from the President's Commission on Mental Health.[3] If this report is successful in influencing future mental health legislation, the emphasis will be even stronger on community-based programs. The report also urges that professionally-developed programs make greater attempts to recognize, respect and build on existing natural helping networks within communities. These goals require that mental health professionals, consumers and their communities develop a working partnership in their efforts to provide effective services. This partnership calls for the development of more effective coordinated mechanisms for community and consumer participation at all levels.

Past attempts to increase consumer/community participation in Health and Mental health programs have met with many problems. Some of the questions raised by these problems are the following:

1) Who is a "consumer", a "community representative"? How and by whom should these terms be defined? For example, in the case of Comprehensive Health Planning Agency Boards many of the "consumer" representatives who were to comprise the Boards' majorities were found to be more "provider" in orientation and experience.[4] The guidelines for definition were so broad that HSA professional staffs were able to select persons who would tend to agree with the professional/provider viewpoint. The current Health Systems Agency Boards seem to be following a similar pattern.

2) What should the selection process be? How can it be assured that persons who do participate will be truly representative of their communities

and of the consumer perspective? Typically, electing representatives does not attract a large turn-out of voters, whereas self-selected or appointed leaders may not have grass-roots support.[5]

3) What should be the nature of "participation" to bring about best results? In Arnstein's ladder of citizen participation, seven levels are postulated. (Figure 1).[6] Moving from the top to the bottom of the ladder, degrees of citizen power in a situation are characterized as participation that results in control of the delivery system, a form of delegated power to influence the system, or a partnership role in relation to the system activities. Degrees of limited participation, called tokenism, exist when the delivery system retains its power for the most part and citizens are either placated or used as consultants in a way that limits their real influence on important policy decisions. States of non-participation exist when citizens become patients or clients and they are objects of therapy and manipulation by members of the delivery system.

Which level is most appropriate for which situations? Again, who is to decide? Participation at the five lower levels often results in little more than incremental change occurring within the system. There is also evidence that maintaining participation at these lower levels often results in participants ultimately feeling used, co-opted, powerless, or becoming apathetic, hostile, or distrustful.[7] However, experiences with participation at the top levels (although much fewer in number) do not offer clear evidence of success, either. OEO programs which were citizen-controlled are often cited as examples of how such programs are apt to be as poorly managed, unresponsive and ineffective as their professionally-controlled counterparts.[8]

4) How can consumers and communities best be prepared to take on new roles of active, effective participation? It is generally agreed that neither

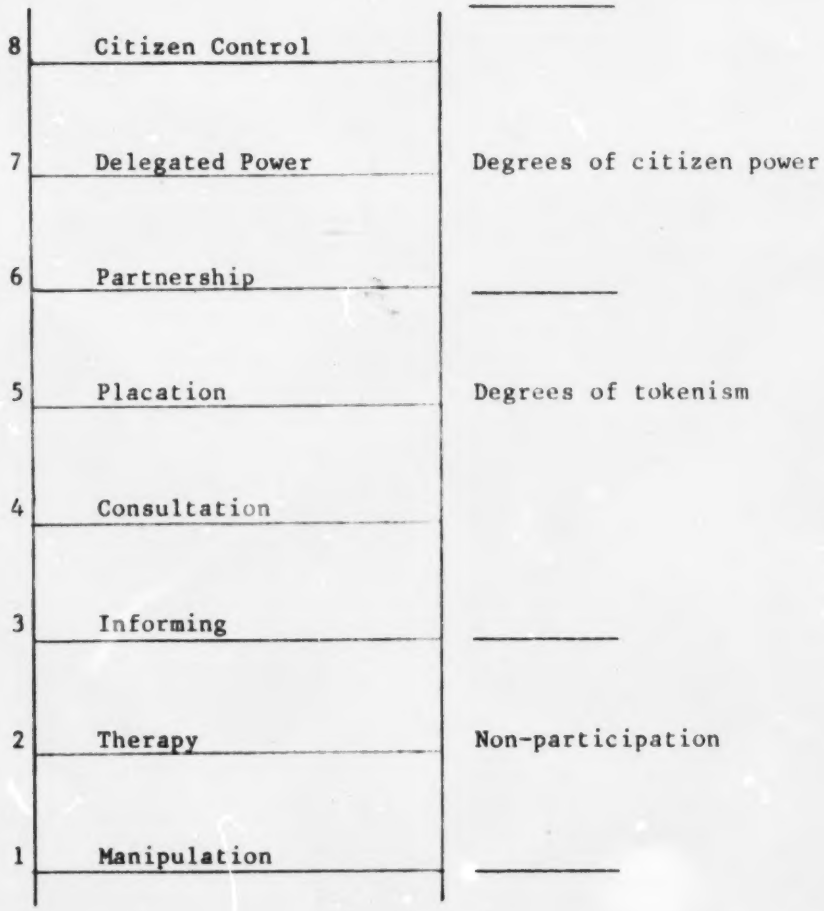


Figure 1

Arnstein's Ladder of Participation

consumers nor professionals have the developed skills necessary to work together in effective partnership. What kind of training programs (if any) should be available, and who should control them?

5) What should the role of the federal government be in the mandating and regulation of consumer/community participation in mental health services? How explicit should regulations be in spelling out who should be involved? In such top-down mandating of participation, agencies often resort to number-juggling and tokenism to meet what they perceive as unrealistic and meaningless requirements.

A survey of the literature on consumer/community participation suggests some important considerations in answer to these questions:

1) Consumers and community members must become active participants in all phases of the service delivery because they hold crucial information about the system which the provider will never have. "Consumers are better than professionals at several key tasks, such as setting institutional goals, and devising economic or political sanctions..."[9] "We must recognize and accept the fact that it is the consumers of health services who are the final and proper judges of what kind of services they want, how they want them delivered, what form they should take, and in what setting they should be provided. It is only on medical and other technical details that the health professionals have any exclusive right to make decisions."[10]

2) Consumer/community participation has little impact unless it occurs at the decision-making level. There needs to be a redistribution of power at these levels, so that participants are not merely advisory but have definite power to affect change. Bloom relates this consideration specifically to the mental health sector when he states the need for decision processes to be democratized. He refers to Iscoe's concept of the "competent community", which requires power and clout as prerequisities to the growth of self-esteem.[11]

3) Consumer/community representatives, acting as individuals, rarely impact significantly upon service delivery systems even if they are involved at decision-making levels. Such individuals often become intimidated when they participate on boards, planning bodies, commissions and other groups that are dominated by professionals. Likewise, such representatives often become co-opted into accepting the professional's viewpoint. There is a need for definite structures and mechanisms, independent of control by the service delivery system, which can organize communities and consumers in ways that create selection processes that enhance the likelihood of true representation. Again, Iscoe's "competent community" notion is useful here: "Conceptually, the competent community is one that utilizes, develops, or otherwise obtains resources including of course the fuller development of the resources of the human beings in the community itself. In this respect, the concept of the competent community parallels the concept of positive mental health."[12] Such problem-solving capacities are not likely to develop spontaneously within a community.

4) There is no guarantee that by increasing the degree and scope of community/consumer participation will services be immediately and dramatically improved. Reissman and Gartner say that "bringing soul to the system does not necessarily improve its efficiency, though it may change its atmosphere and character...the unfreezing of the equilibrium of human service does not guarantee improvement, it provides an opening for such improvement."[13] Hochbaum emphasizes that there are many underlying social, political and racial issues that must be dealt with in these attempts before any marked improvement in outcome results.[14]

These warnings imply the need to avoid looking for concrete service outcomes too early. Some of the typical criteria used in judging a system's

effectiveness should also be questioned. To a large extent we do not know what the outcomes will be of a system that has developed extensive, workable consumer/community participation, because so few examples exist to give us clues. Some of the results which may be quite satisfactory to the consumer and community may very well not satisfy the professionals.

5) There exists the need for a re-orientation on the part of professionals and consumers concerning their proper roles in the delivery of services. A growing body of criticism is pointing to the ethic and culture of "professionalism" as a significant deterrent to the consumer explicitly, in the belief that they possess superior knowledge; not just knowledge of their profession's theory and technology, but also of the nature of the needs and experiences of their clients.[15] Clients and society at large tend to reinforce this belief by behaving in overly dependent ways in relation to professionals. Thus, professionals on the whole are given an enormous amount of power to control the service-delivery process - control that has benefited them economically, but which also has led to completely unrealistic expectations and a rising anti-professional attitude on the part of the client-public. Both professionals and consumers need to readjust their expectations as to what both can and should provide in the service delivery process.

6) Finally, there is a need for the development of specific conceptual models, approaches, and strategies to increase consumer/community participation that take into account these and other problems. It is particularly critical to develop approaches that do not place the participants in a dependent or subordinate position to the professional delivery system. As Metsch and Veney note, "On the one hand, research findings clearly suggest the need for a high degree of specificity in the mandating of consumer participation if the consumer sector is to be a real and viable force... In addition, we conclude that overemphasis on the restructuring of the participative process will result only in incremental rather than substantive change unless a

complementary strategy is developed which dramatically destabilizes the current power balance between government, providers and consumers."[16]

The following section offers a conceptual model of human service systems that represents such an approach to power destablization. Part II describes the approach itself, and offers a case history as an example.

The Balanced Service System

As the foundation to a balanced service system we postulate that any service system is composed of four generic stakeholder groups. We call these groups constituencies to emphasize their social power relationship. As an example, let us consider the mental health service system of a particular community - say Catchment Area X. The system would be defined as all persons who relate to the formally-designated, professionally-authorized mental health services of that geographic area. The constituencies of that system would include stakeholder groups that represent common interests and attitudes such as the following:

1) Resource Providers - This constituency includes persons and organizations who provide financial and human resources, legitimacy and authority as stakes (their share and interest) in the service system. This group would include federal, state, and local funding sources; professional training institutions; accrediting organizations; private foundations, etc. It would also include persons who make policy for the various services within the system, such as legislators, boards of directors, advisory groups, etc.

2) Technology Developers - These are persons who take the resources provided by the first group and turn them into programs for delivering mental health services. Their stakes consist primarily of the knowledge and skills that are useful in organizing and administering the social system. This group includes mental health agency and other relevant human service agency administrators, both top and middle management; researchers; and teachers in

professional training programs. Members of this group tend to identify strongly with their respective professions and the opportunities for gaining status within the service system. Therefore, many mental health professionals tend to identify more as a Technology Developer rather than a Direct Service Provider (described next) even if they are not in administrative positions.

3) Direct Service Providers - These are persons who function within the structures designed and managed by the Technology Developers and who deliver services to the consumer. Their primary stakes are the knowledge and skills that are useful in providing helpful services to the clients and, at the same time, gain professional status in the eyes of professional peers. This group also includes such auxiliary groups as paraprofessionals, support staff, volunteers, student trainees, etc.

4) Service Acquirers - These are persons who consider themselves primarily as consumers, or advocates of consumers, such as patients or clients of the mental health system. Their stakes in the service system consist of their "rights" to obtain the services and their desire to meet personal or group needs. Also included in the constituency are institutional consumers of mental health services, such as school, law enforcement, hospital, and other service personnel who might receive consultation or training from mental health professionals. And finally, this constituency includes persons who may not necessarily be actual consumers or formal advocates, but who represent the overall community interest in the area of mental health service. They may include clergy, local elected officials, community leaders, and other interested parties.

The constituency composition of the mental health system in Catchment Area X is illustrated in figure 2. A mental health system therefore consists of four constituencies as they relate to the delivery of formally-recognized mental health services within a designated geographic area.

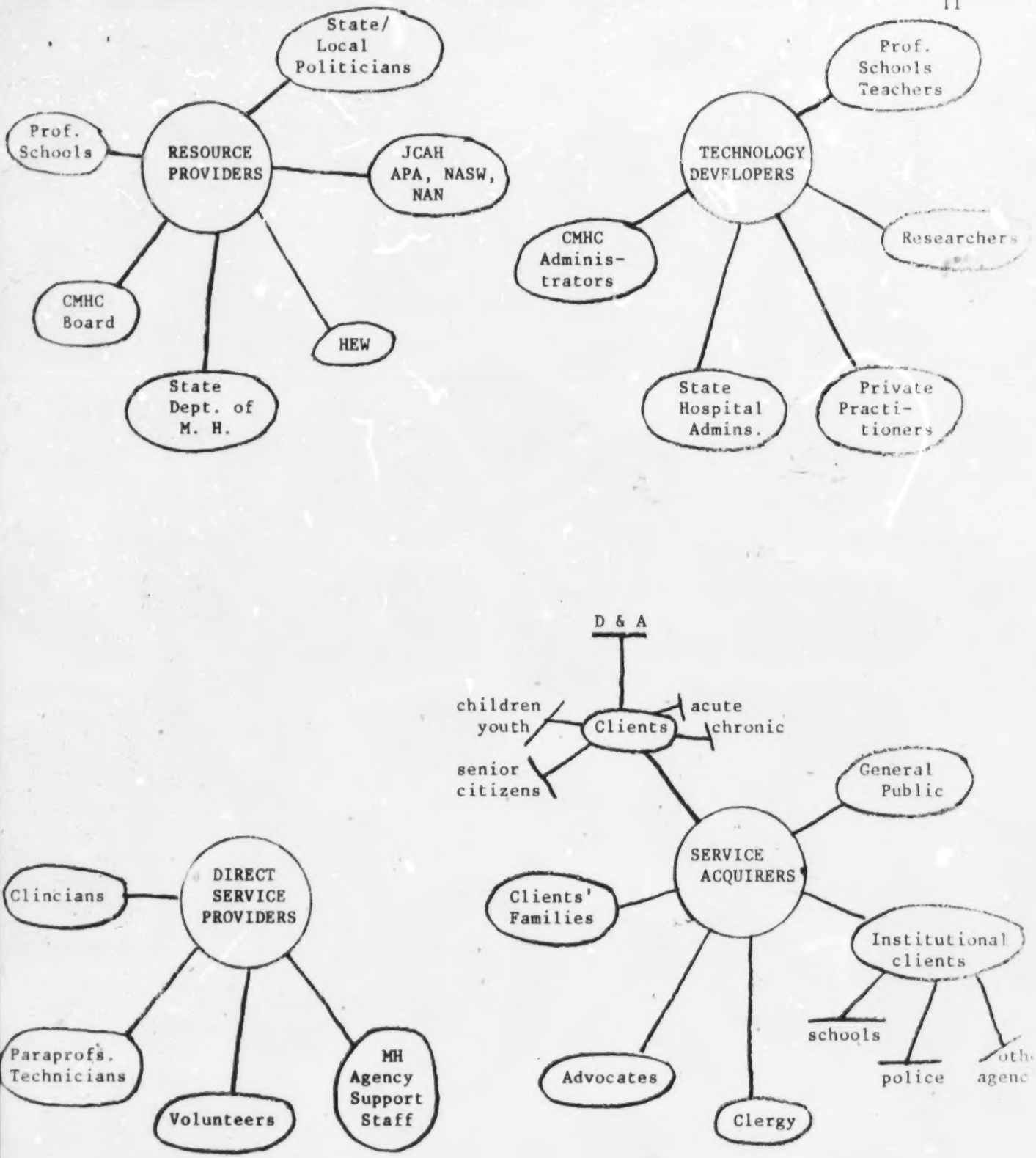


Figure 2

Constituencies of the Mental Health Service
Delivery System in Catchment Area X

A person may occupy more than one role and therefore be a potential member of more than one constituency within a given service system. However, he or she usually will identify more closely with one constituency over the others. It is this sense of role identification which is the ultimate arbiter of which constituency a person belongs to. The common bond between members of a given constituency is their unique experience of and subsequent information about the system that is not shared by any other constituency.

We further postulate that such a system can be conceptualized as being comprised of two main components, the Service Delivery System, which is primarily concerned with the allocation of resources, and the development of structures and technologies to convert those resources into services - and 2) the Service Acquisition System - which is primarily concerned with articulating what are the needs that require what kind of services, prioritizing those needs, and then pro-actively acquiring services to fill the needs.

The diagram in figure 3 represents a normative Balanced Service System, and suggests the following as characteristics of such a system:

1) The experiences of and subsequent information about the system are more similar between members of intersecting constituencies. Thus, a person who is a volunteer and falls into the direct service provider constituency may also feel a strong identification with the service acquirer perspective. Likewise, a social worker who has a large clinical caseload at a CMHC may be completely baffled and extremely inconvenienced by the rationale for certain administrative procedures mandated by funding agencies. Whereas the agency's director, who also may be a social worker by profession, can sympathize with both sides.

2) Each constituency is perceived by the rest to be equal in its importance to the system, and that its power to influence the function of the system is in balance with the others.

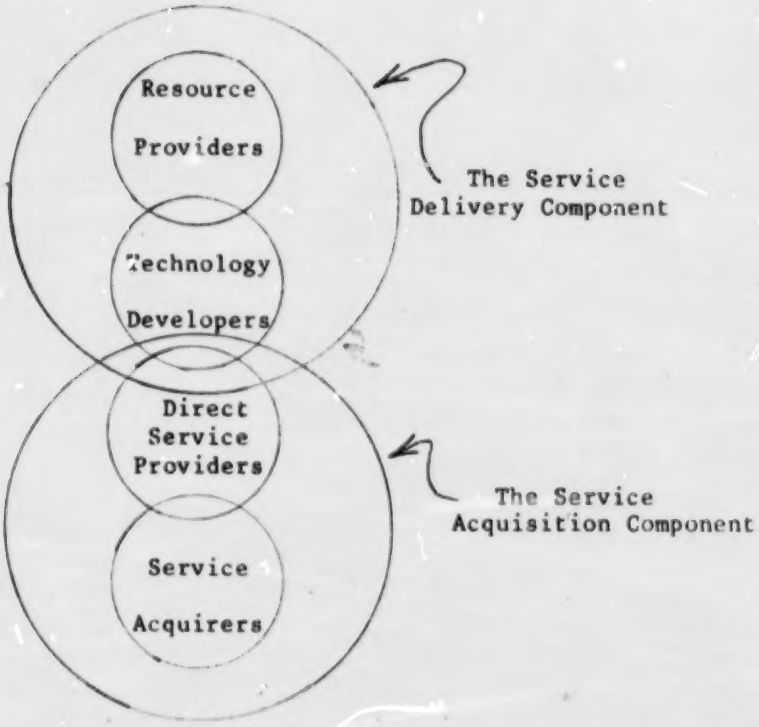


Figure 3

A Balanced Service System

3) Each constituency is a well-defined, recognized and legitimized subset of the total system, with organizational structures to support it. Also, each constituency while sharing some things in common with other constituencies, essentially holds a very different, often conflicting, and equally valid viewpoint about the needs and priorities of the overall system.

These are the hallmarks of what we refer to as the Balanced Service System. It seems reasonable to conclude that our mental health service systems today (indeed, many of our human service systems) are quite unbalanced in relation to this ideal model. More specifically, a service system is unbalanced (Figure 4) when:

1) The system is dominated by the power of the service delivery component, particularly the resource provider and technology developer constituencies. These constituencies, which are primarily controlled by the various mental health professions, do not simply concern themselves with

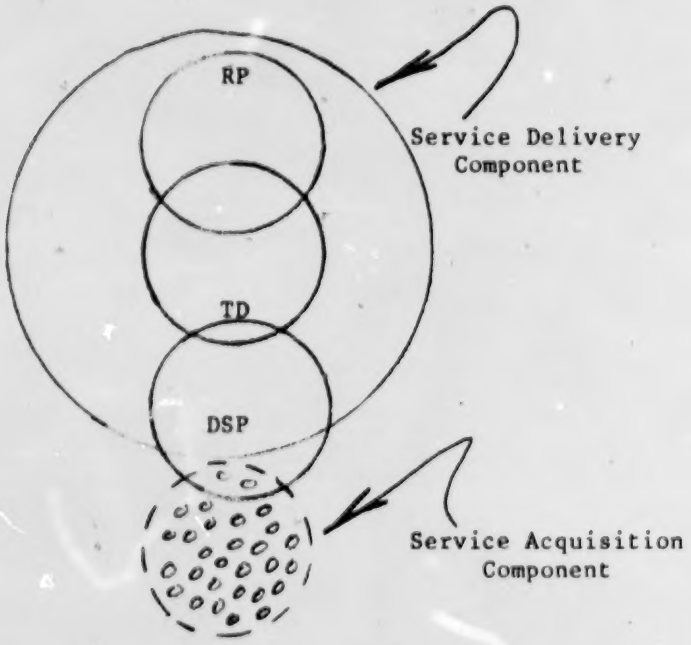


Figure 4

An Unbalanced Service System

allocating resources and designing systems and technologies to convert those resources into services. They also make most of the decisions about what the service needs are, what priorities should be, and who should be served in what fashion. They dominate the policy-making, planning, implementation and evaluation functions of the total system. Although they may devise ways for service acquirers to provide opinions and information from their perspective, that information is usually taken from the service acquirer and used by the professionals to affect changes that will not threaten the imbalanced status quo.

2) The service delivery component is well-defined, legitimized and recognized by all elements of the system and its environment. The constituencies within the system are easily recognizable, and have obvious supporting organizational and professional structures and boundaries. Members of these groups tend to feel a strong constituency identity. In contrast, the service acquirers component is amorphous, and its members are usually isolated from each other. Some of them are labeled as helpless, weak, inferior or possibly dangerous. There are few lines of communication among them and few supportive structures. There are few channels of communication between the components, other than the individual relationship of client to professional, which is too often a one-way street for the client.

3) The relationships among the constituencies are marked by inequality. The most important information and viewpoint within the system is usually perceived by all constituencies to be that of the professionals by virtue of their advanced training and expertise. The value of information tends to be judged according to the power of its source rather than by the quality of its content. Service acquirer information is therefore considered less important, less reliable, and less informed. It may be taken into consideration by the service delivery component, but usually only as an adjunct to professional judgement.

We are not critiquing the individual one-to-one client/professional relationship which, in many cases, is marked by mutual respect, equality and a balance of power. It is when one steps back and looks at how the individual client and professional relates to his/her constituency and the total system that the imbalance and inequality become evident.

PART II

How does an imbalanced service system become re-balanced? How can the inherently disorganized and weak service acquirer constituency become organized and strong enough to grow into a service acquisition system? This is not likely to happen on the initiative of the service acquirers alone and unaided, for two reasons. First, persons in service acquirer roles tend to see themselves as having little information, time or expertise to contribute to what they perceive as the foreign, incomprehensible matters of a professional service delivery system. Or, even if they do believe they have something to offer, they perceive themselves as being powerless to change the system. Second, those groups which have succeeded in organizing independently of the professional system (such as self-help and mutual aid groups) while being very effective in their own ways, are not usually able to make significant impact on the workings of the service delivery system. Their orientation is often "anti-establishment", and they operate virtually apart from the professional system.

As it is unlikely that a strong, powerful service acquisition system will develop spontaneously from a scattered service acquirer constituency, it is equally unlikely that the professionally-dominated service delivery system will be able to make it happen. Many professionals affiliated with a system sympathize strongly with the need for increased service acquirer influence, and may even agree with the concept of an independent service acquisition system. However, if those persons were able to lead the process of development it would still be the professional system allowing service acquirers to organize under the sanction, control and leadership of the professional. The result of this approach tends to <u>not</u> develop an independent service acquisition base from which to negotiate with the service delivery system.

No matter how sympathetic a professional may be, his or her primary role in and experience of the system is as a professional. To choose this is to assume certain vested interests and priorities that will inevitably conflict with the service acquirer perspective. These biases are natural and legitimate. They cannot and should not be set aside. For professionals within a system to attempt to develop service acquisition systems is extremely difficult, for it would place them in the position of either trying to fight their natural biases, or trying to co-opt the service acquirers into seeing things from the professional point of view. Professional leadership in such an effort can reinforce the dependence that service acquirers tend to have on professionals.

With these limitations in mind, we have taken another approach in our work in creating service acquisition systems. We have developed an approach that utilizes the concept of a third-party developmental staff that is external to the system involved. This staff is composed of a group of persons who have a minimum of self-interest in the content outcome of the system being developed, and who have no formal ties to any relevant parts of the organizations involved. Developmental staff members have knowledge and skills in group, community and organization development, including process facilitation, problem-solving, and conflict management. The following is a case history of the development of a service acquisition system by a third-party staff.

CASE HISTORY

The Tennessee Association for the Management of Human Services (TAMHS) is an independent, non-profit, membership corporation that was developed by a third-party staff at the Center for Research on Human Service Systems (CRHSS) from 1973-1978, using the constituency-based approach. It is currently the Center's most fully-developed example of a service acquisition system, although previous projects undertaken by CRHSS utilized the constituency-approach to varying degrees.[17] The following is a brief history of the project as it highlights the major steps in the developmental process. The characteristic outcomes of the developed service acquisition system are also discussed.

CRHSS received a National Institute of Mental Health (NIMH) training grant*, and funds from the Tennessee Department of Mental Health/Mental Retardation (TDMH/MR) to develop an inter-disciplinary, consumer-oriented training network for Community Mental Health Center (CMHC) managers. From the beginning, the project director and his staff held the position that the content, design, and nature of the resulting training system should be determined primarily by the potential users of the system - the CMHC personnel. This position was basically adhered to throughout the entire project period. The strategy of the project staff was therefore to design and implement project structures and processes that would reinforce this strategy and at the same time, as much as possible, remain neutral to the content of the training program being planned. Therefore, they directed their efforts at encouraging the development of organizational structures that would reinforce the constituency nature of the ultimate program.

*NIMH Grant #5 T01M 13706

The following were the major phases of the project:

The project director and a core staff spent two years (1972-1974) laying groundwork for the project. Support was sought and secured from the TDMH/MR and the Kentucky Department of Human Resources. Visits were made to nearly all CMHC's in Tennessee and some in Kentucky to inform Center directors of the project and obtain their support. Support was also solicited and received from five different universities and colleges in Nashville. The pre-project efforts culminated in a workshop to gather baseline information on management training needs. Workshop participants included representatives of the major constituencies of the future program. Each constituency met separately in the workshop to generate information on CMHC management training problems and needs through a structured problem identification process.[18] In this way, the workshop modeled the overall structure and approach of the future project.

During this early period of development the service system was an ill-structured system. (Figure 4a) That is, there were few lines of communication or organizational structures between the constituencies. Each operated virtually independent of each other despite their common interest in seeing CMHC personnel adequately trained in management. It was the goal of the project staff to help the constituencies to organize themselves around their priorities regarding CMH management training needs, and to begin to communicate and negotiate with each other in developing a system to get those needs met.

The project began in July, 1974 and the staff spent the first six months conducting management problem-solving workshops at a total of seven CMHC's in Tennessee and Kentucky. These two-day workshops had two initial purposes:
1) to gather further detailed information about CMH management-related problems that would provide a foundation for the training system design, and
2) to offer participating centers an opportunity to involve their own organizational constituencies in a major problem-solving project around that

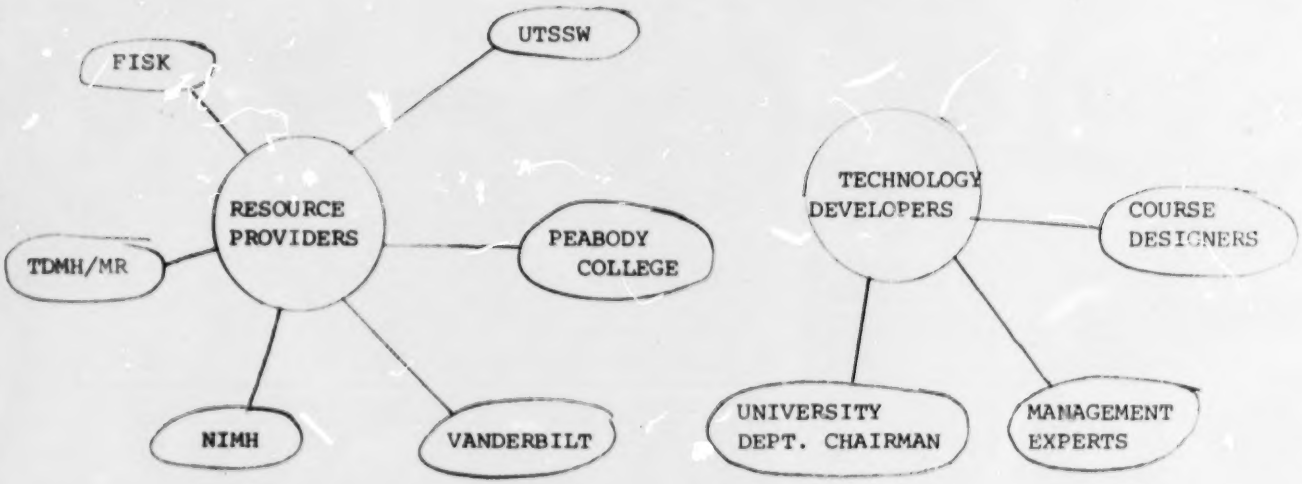
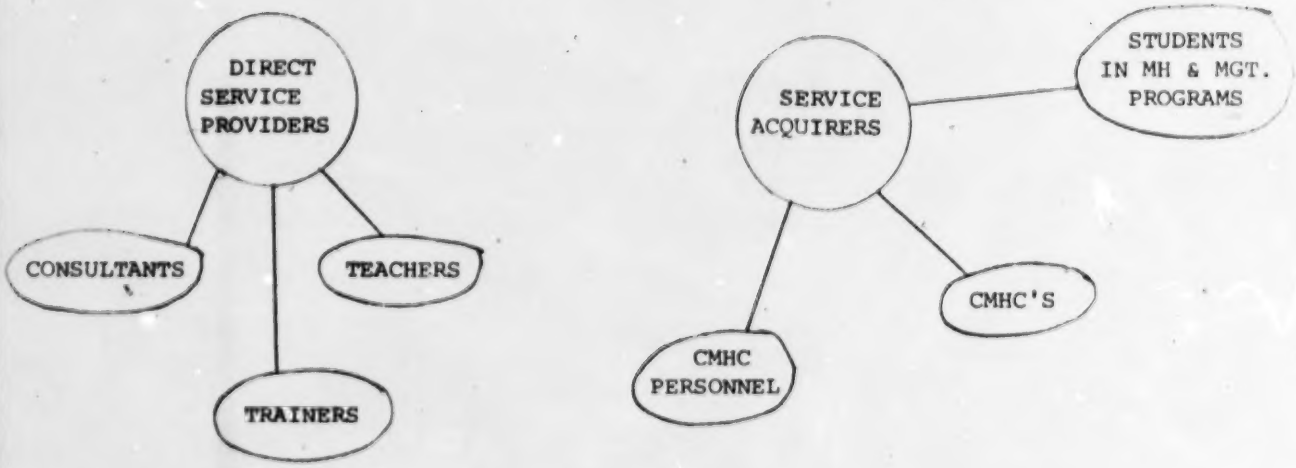


FIGURE 4a

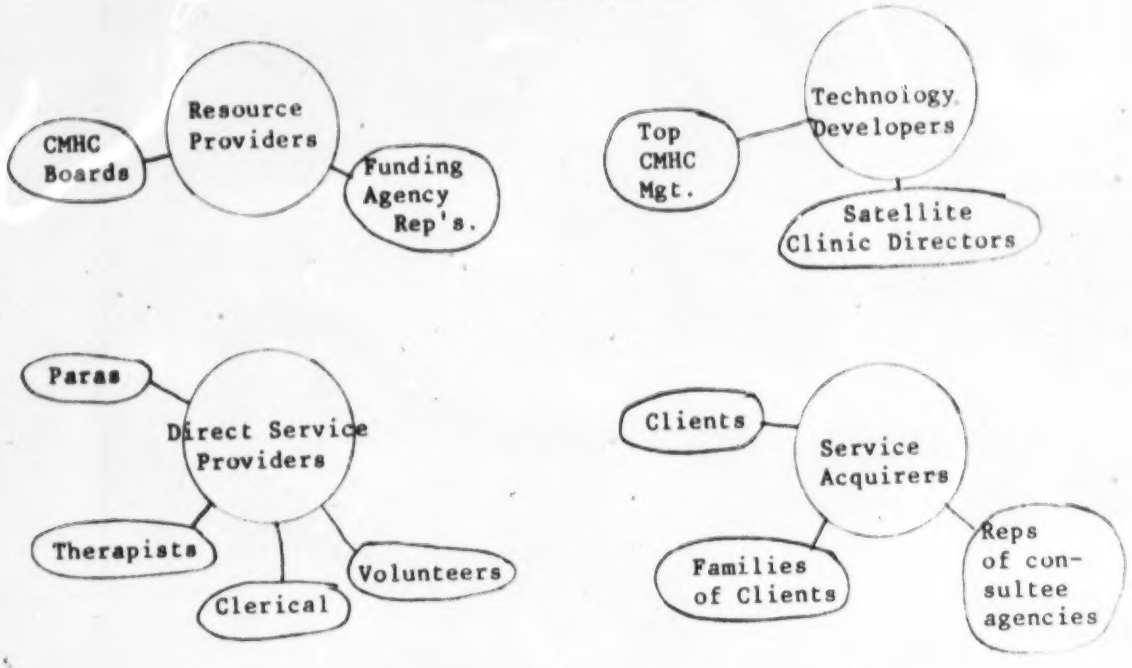
EARLY CONCEPTUALIZATION OF THE CMH MANAGEMENT TRAINING SYSTEM IN TENNESSEE & KENTUCKY



particular Center's own needs. The project staff conducted these workshops by dividing the participants into their respective constituencies, and taking each group separately through a structured problem solving process.[19, 20] The project staff also provided follow-up consultation with each Center in helping them implement solutions to the problems identified. A typical CMHC workshop involved anywhere from 35-70 participants, representing the following constituencies:

Figure 5

CMHC CONSTITUENCIES



A large volume of data in the form of problem statements and action plans resulted from these workshops. An important process outcome was the high degree of commitment to the developmental training project on the part of many of the participants. The workshops provided a common experience for the participants that laid the foundation for a strong service acquirer constituency.

As the workshop phase was ending, the project staff turned its attention to organizing a group of representatives of academic training programs in the four mental health disciplines. This group consisted of representatives from graduate programs in nursing, psychology, psychiatry and social work, and had as its stated goal the development of a strategy for an interdisciplinary curriculum in CMHC management. The foundation for this curriculum was to be the data generated by the CMHC problem-identification workshops. The project staff met several times with these academicians to assist them in their usage of the data. The staff and the academic group conflicted over their respective definitions of their roles. Primary issues related to opinions about the utility of the problem data and the desirability of the group/constituency development approach to the project. More traditional methods of curriculum development were preferred by many.

The academics eventually decided to work alone on their task, and the project staff once again turned its attention to the CMHC personnel. In February of 1975, seven months after the project began, the project staff called a meeting of all interested persons who had participated in the CMHC workshops. The goal of the meeting was for members to share each Center's data, and to decide what were the group's overall priorities for management training. Thirty-five people attended this meeting. The project staff acted as facilitators of this and subsequent meetings. This group evolved into a working core of 8-15 persons who became the ongoing representatives of the service acquirers constituency. It included Center Executive Directors, business managers, board and community representatives and clinicians of several CMHC's.

Over the next three months, the academic and CMHC groups continued to meet separately to accomplish their respective tasks. The project staff functioned as meeting-facilitators, data-gatherers, and logistic-coordinators for both groups. They also provided between-meeting communication and clerical support. Both of the groups were aware of the other group's meetings, but it wasn't until April of 1975 that the CMHC group was ready to meet with the academic group and share their work.

The meeting was a heated one, with the CMHC group expressing frustration at the long, drawn-out process they had been through with as yet no tangible outcome. They called for the immediate development of pilot workshops tailor-made to the needs of the working CMHC manager. The emphasis had clearly shifted from the development of a degree-granting, academic curriculum to practical, continuing-education workshops that would respond directly to stated needs of the service acquirers. In this respect, the forum made the first major decision in the evolution of the training program: to give priority to field-relevant, accessible training for CMHC managers over formal academic programs. The decision was a clear reflection of the service acquirer priorities.

The other major outcome of the meeting was the emergence of an issue that would take many months to resolve. In calling for the immediate development of workshops, the question of who should take over the actual program planning work was raised. Members of the CMHC group argued, quite correctly, that they all had other full-time work commitments that precluded their doing such work. Some of the academics were willing to assist, but it was clear to them and the CMHC members that the academic orientation would tend to hamper their ability to develop field-relevant workshops. Members of the project staff were willing. But they were also mindful of the need to spread ownership among the constituencies, and to assist in the development of some on-going staff

capacity that would outlive the project period. The solution arrived at was a working group composed of all three groups.

The staff did much of the work in the beginning, but over the course of the next three years the division of roles became much more explicit. By the end of the Year 2, a program staff had therefore evolved entirely separate from the project staff.

The first half of Year 2 was spent by various working groups in the planning and execution of several pilot training projects. It also saw the organization of another service acquirer sub-group - the Student Constituency Group (SCG). They were primarily full-time graduate students in social work, psychology, nursing, and management who were the recipients of stipends attached to the NIMH grant.

In February of 1976 (Mid-Year 2), representatives of all constituencies met again to review the progress of the project. They decided to establish an ongoing executive committee made up of representatives from each constituency to provide continuity and to design ongoing organizational structures. (See Figure 6.) This body met regularly for 6 months, and at the end of this period had designed the basic structures for a non-profit, independent corporation devoted to consumer-oriented mental health management training. The name chosen was the Tennessee Association for the Management of Human Services (TAMHS), to reflect an orientation potentially broader than only mental health management. The program was incorporated as a non-profit corporation in the State of Tennessee, and elected its first Board of Directors in October, 1976.

During the six months prior to incorporation, the project staff assumed a more consultative role, and withdrew from its facilitating/initiating roles. The staff increased its preoccupation with transfering ownership of the program to the constituencies. This was also a period of high conflict between the emerging program and the project staff, stemming from the withdrawal of the project staff as the primary source of support and leadership. This "separation trauma" was

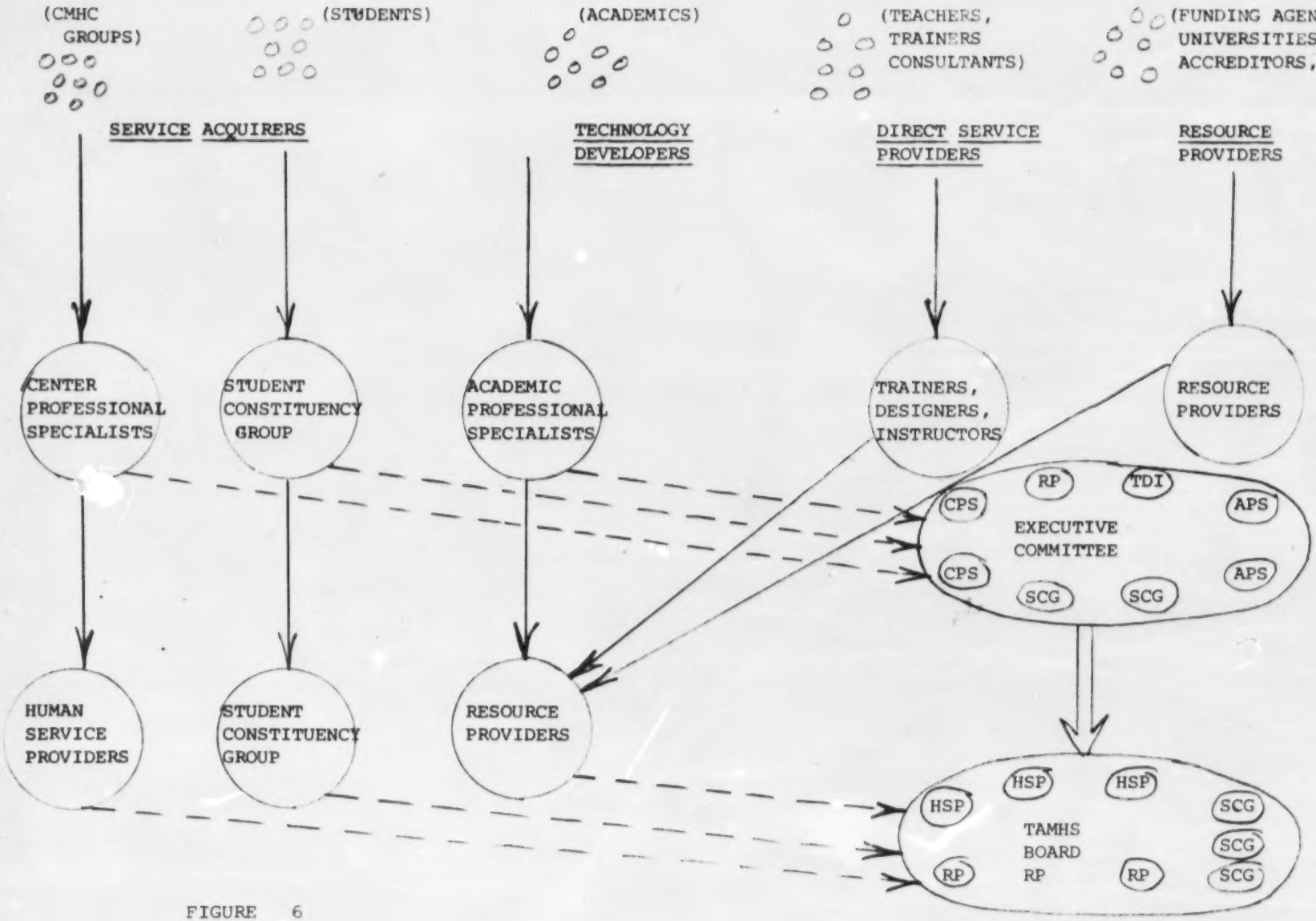


FIGURE 6

EVOLUTION OF TAMHS

a difficult phenomenon to manage, and was a central problem during most of Year 3 (1976-1977). By the beginning of Year 4 it had been essentially resolved.

During the final two years, the fledgling organization called TAMHS, had to deal with some very difficult problems. These included establishing organizational structures that would reflect its constituency nature; formalizing policy; negotiating with the project staff and its NIMH funds for further financial support; designing, promoting and sponsoring a series of workshops; and struggling with the problem of funding after the federal grant expired. An Executive Director was named, and a program staff organized under his direction. The project staff decreased its direct involvement greatly, and by Year 4 the small remaining project staff functioned only as consultants when expressly called upon.

Characteristics of a Service Acquisition System

With this case history as background we will now highlight some of the important characteristics of TAMHS as a service acquisition system.

1) It is user-dominated. The composition of the Board of Directors is two-thirds service acquirers who are elected by their constituencies at an annual meeting. The other members represent the other original constitiuencies.

2) It has an established norm of looking to its own resources to satisfy its needs before going to "experts". Service acquirer constituency members have agreed that the management training being offered by academic programs, training experts and consultants uniformly failed to meet their needs. As TAMHS grew it came to value more and more the expertise within its own membership, not only in articulating problems but in discovering and sharing solutions. Thus, most workshops are designed and conducted by members of the constituency who requests it, with the help of TAMHS staff. Facilities and supplies are usually donated by member agencies. The individual fee for a typical TAMHS workshop is $5, with attendance varying from 30-150. The TAMHS

staff and Executive Director do not see their roles as determining the content of workshops. Their roles are designed to stimulate constituency members to articulate their needs, and to help them plan training offerings to meet them.

3) It is constituency-based. The TAMHS Board consists of elected representatives of the constituencies. To assure that these persons retain their constituency orientation and do not become completely immersed in their Board role, a separate position of Constituency Administrator was created. This person has no hierarchical authority within the organization, but instead is charged with keeping communications flowing with his/her constituency. The Constituency Administrator calls constituency meetings to elect Board representatives and ascertain members' priorities, and keeps tabs on how well the Board members are representing the constituency's interests. By-laws require each constituency to meet at least annually, and all Board members must stand for re-election once a year.

The constituency-based developmental process has also established an orientation among members that causes them to consider their constituency membership as primary over their TAMHS membership. Thus, TAMHS exists only as constituency needs and interests exist. Holding workshops or other training events when there is not strong evidence of at least one constituency's ownership and interest is considered pointless. As a result, workshops are consistently "successful" when judged by the criteria of attendance and participant satisfaction.

4) It has developed a power-base to be able to negotiate with the established service delivery system. In this case, the established system would include existing academic and other professionally-run programs offering courses, curricula and workshops in management for human service personnel. Relevant issues to be negotiated with the components of this system would include the quality and relevance of the academic preparation of students who

enter positions in these agencies; the distribution of funds (especially from state and federal sources) to support technical assistance work; and the requirements for accreditation and other forms of approval mandated by governmental and other regulatory agencies. TAMHS has the potential to be influential in all these areas because of its wide basis of support among a number of human service organizations.

Conclusions.

TAMHS is the most fully developed service acquisition system created to date by CRHSS. It was preceded by several other projects which utilized elements of the constituency approach. The overall conceptual model draws from those as well as the TAMHS experience. We believe the model has been adequately "pilot-tested", and is refined enough to become a subject for rigorous research. However, there are several problem areas that need to be addressed in future applications of the model in the field of mental health service. They include the following:

1) In the TAMHS experience, the service acquirers were mental health professionals. It has been suggested that such persons possess advanced skills and knowledge that enable them to better handle the task of creating and maintaining a service acquisition system than a less educated, non-professional consumer. Our past experience with other projects suggests this is not the case. We have found that most people, regardless of their backgrounds, tend to underestimate their abilities and expertise when they are acting in a service-acquiring role. The CMHC Executive Directors who were central to the CMHC group's development considered themselves in the beginning to have little legitimate management expertise, and consistently appealed to the project director to lead them to management experts to design training programs. In past projects, recipients of health and mental health services often began their involvement with the same degree of self-denigration. Both

groups, however, were able to perceive their latent expertise and abilities once they were brought together with others "in the same boat". We have found that it is the degree of constituency identity and development, and not educational background, that is the key factor in service acquirer effectiveness.

2) Another question concerns the likelihood of finding enough committed service acquirers who would be willing to put the large amount of time necessary into developing a service acquisition system. Again, our experience indicates that when people become involved in something in which they have the power to significantly influence its outcome, their level of ownership is very high, and they are willing to invest much time and energy to see their work succeed. During the course of the TAMHS experience, there were several periods when constituency members experienced conflict, frustration, circularity, and a general "going nowhere" feeling. At each of these points, key people came together to confront the situation, and each time made explicit decisions to devise a strategy for moving forward again. At no time did the project staff make that decision for the organization.

3) The role of the third-party developmental staff is an important area with several unresolved issues. First, we believe a third-party staff is crucial to the service acquisition system's development, because of its neutrality and relative lack of vested interest in the system's content. Since it is crucial, does that make this approach infeasible because of the cost involved in supporting such a staff? Who should be the funding source for the staff? If it is funded by a part of the service delivery system, the staff may be placed under pressure to soft-pedal any results which might threaten the status quo. At this point we are not clear about who should provide this support. We are presently exploring the possibility that existing community and consumer-oriented organizations, such as Mental Health Associations,

Associations for Retarded Citizens, private and public foundations and the like, would be logical sources of support. In past projects, state and federal agencies, expecially branches concerned with research and development, have provided us with support. But ultimately those agencies represent the interests of the professional service delivery system, interests which only occasionally coincide with those of the service acquisition system.

Second, the third-party staff must itself possess an unusual array of skills and an orientation not commonly developed as a matter of course in most professional training programs. Members must be committed to allowing the content of the program to be determined by the constituencies, regardless of their professional biases. They must be committed to an on-going process of developing their own capacities for role differentiation, conflict management, strategic management, and negotiation. As they become more proficient among themselves in these areas, they are better able to act as facilitators, advocates, negotiators, staff support, consultants, and fundamental role models for the evolving system. We are still struggling with the problem of transferring these skills to other potential third-party staffs. It seems quite unlikely that such a transfer can take place simply by writing and reading about the process.

4) The constituency approach is, at its core, a conflict model. That is, the approach recognizes and reinforces the inherent conflict of interests among constituencies of any system. It operates from the assumption that unless these conflicts are aired and dealt with, the system will continue to be imbalanced and ineffective. A central goal is the development of mechanisms to recognize, negotiate and resolve conflict among constituencies.

However, once conflict is uncovered and made explicit, it can be very threatening to all concerned. The approach requires that prior to the start of any constituency organizing activity, key people within the system who have ultimate power to sanction or stop the developmental process must be brought

on board. These people comprise what we refer to as an "umbrella group".[21] They may not become personally involved in the organizing process, but they must understand and be willing to tolerate and contain the conflict which will inevitably occur. It is a major task of the project staff to work with and through these people in the early stages of the project to build this strong support.

5) The constituency approach takes time. We estimate that in future applications the development time could be cut from four to two years. But even this is a substantial period, especially in an era when funding sources often require early quantifiable results. However, we maintain that the approach is one which directly faces the problem of successful implementation by taking enough time to develop constituency ownership and commitment. It allows the constituencies involved to openly deal with conflicts that, if skimmed over lightly, could seriously hamper the system's functioning at a later date. Thus, we believe that initially it is essential to allow for this fairly long development period in the interests of future system effectiveness with the expectation that part of the gain in effectiveness will result in a shorter and shorter time for service acquisition system development.

We believe that the constituency approach to developing service acquisition systems is a viable strategy that can help to rebalance the maldistribution of power in the overall mental health service system. It is an approach which directly faces the need for increasing community and consumer participation in service system planning and development. It particularly addresses the difficult questions of how consumer and community representatives should be identified and selected, and offers a specific mechanism for their participation that minimizes the chances of co-optation, and maximizes independent action. It offers participants a way to become proactive acquirers of services rather than passive recipients. And finally, it provides a way for service acquirers and service providers to work as active partners in developing ways to deal with the mental health needs of our society that addresses a critical societal problem.

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